



social care  
institute for excellence

# **Diocese of Chester independent safeguarding audit (May 2016)**



The Social Care Institute for Excellence (SCIE) improves the lives of people who use care services by sharing knowledge about what works.

We are a leading improvement support agency and an independent charity working with adults', families' and children's care and support services across the UK. We also work closely with related services such as health care and housing.

We improve the quality of care and support services for adults and children by:

- identifying and sharing knowledge about what works and what's new
- supporting people who plan, commission, deliver and use services to put that knowledge into practice
- informing, influencing and inspiring the direction of future practice and policy.

First published in Great Britain in March 2017  
by the Social Care Institute for Excellence and the Church of England

© Church of England

All rights reserved

Written by Edi Carmi, Susan Ellery and Hugh Constant

**Social Care Institute for Excellence**

Kinnaird House  
1 Pall Mall East  
London SW1Y 5BP  
tel 020 7766 7400  
[www.scie.org.uk](http://www.scie.org.uk)

# Contents

<b>1</b>	<b>INTRODUCTION</b>	<b>1</b>
1.1	Context	1
1.2	The Diocese	1
1.3	Structure of the Report	1
<b>2</b>	<b>FINDINGS</b>	<b>2</b>
2.1	Safeguarding Management	2
2.2	Diocesan safeguarding adviser/s	3
2.3	Diocesan Safeguarding Commission	5
2.4	Policies, practice Guidance and Procedures	6
2.5	Resources of safeguarding service	7
2.6	Recording systems and IT solutions	7
2.7	Risk assessments & safeguarding agreements	8
2.8	Training	9
2.9	Safe Recruitment of church officers	10
2.10	Response to allegations	11
2.11	Quality of Casework	15
2.12	Complaints	15
2.13	Whistleblowing	16
2.14	Monitoring of safeguarding in parishes as part of Archdeacons' responsibilities	16
2.15	Resources for children and vulnerable adults	17
2.16	Information sharing	17
2.17	Quality assurance processes	18
2.18	Links with national safeguarding strategy and team	19
2.19	National systemic safeguarding issues	19
<b>3</b>	<b>CONCLUSIONS</b>	<b>23</b>
3.1	What is working well	23
3.2	What needs to work better?	23
	<b>APPENDIX: REVIEW PROCESS</b>	<b>25</b>
	Data Collection	25
	Limitations of the audit	26

# 1 INTRODUCTION

## 1.1 CONTEXT

The Social Care Institute for Excellence (SCIE) has been commissioned to undertake an audit of the safeguarding arrangements of each diocese of the Church of England. The aim of these audits is to work together to understand the safeguarding journey of each diocese to date and to support the continuing improvements being made. Following pilot audits of four dioceses in 2015, an agreed audit model is being applied nationally during 2016 and 2017.

The audit of the Diocese of Chester was carried out by Susan Ellery (the lead auditor for this diocese) and Hugh Constant on 10, 11 and 12 May 2016. The report was drafted by Susan Ellery with support from Hugh Constant. Edi Carmi, the overall lead auditor for the project, provided quality assurance and completed the final report.

The audit process incorporated an examination of files and documents, along with meetings with key individuals and a focus group of parish representatives. Details of the process are provided in the appendix, along with an explanation of the limitations of the audit, in particular in relation to key individuals who were not seen, including the Independent Chair of the Safeguarding Commission.

The findings of the audit are provided in section 2, along with considerations for the diocese. Consistent with the SCIE Learning Together methodology of improving practice, 'considerations' are used, instead of 'recommendations': these are not specific actions to take, but issues to consider in deciding how best to improve safeguarding practice within the diocese.

## 1.2 THE DIOCESE

The Diocese of Chester is one of the larger dioceses in terms of area and the number of parishes (about 270). It borders the dioceses of Manchester and Liverpool to the north, Wales to the west, Lichfield and the Potteries to the south and Derby to the east. The Bishop has held office since 1996.

## 1.3 STRUCTURE OF THE REPORT

This report is divided into:

- Introduction.
- The Findings of the audit [links have been made with the S. 11 (Children Act 2004) Church of England national audit form].
- Considerations for the Diocese are listed, where relevant, at the end of each finding.
- Conclusions: what is working well, what needs to work better.
- An appendix sets out the review process, including any limitations of the audit process.

## 2 FINDINGS

### 2.1 SAFEGUARDING MANAGEMENT

#### 2.1.1 Structure

The Bishop of Chester is clear that he has lead responsibility for safeguarding and does not delegate it to any of his staff, choosing to retain overall control. He also exercises direct control over all decision-making in any case involving any person who holds the Bishop's Licence (lay readers as well as clergy). The diocesan safeguarding policy states, 'Within the Diocese, the Bishop carries the ultimate responsibility for decision-making in respect of all safeguarding matters. He also carries responsibilities for dealing with issues that require Clergy Disciplinary Measures in accordance with canon law, and which are further clarified in the national Church of England policies. In fulfilling his safeguarding responsibilities, the Bishop is assisted by the Archdeacons, and advised by the Diocesan Vulnerability and Safeguarding Officer and the Diocesan Safeguarding Commission.'

The Diocesan Vulnerability and Safeguarding Officer (DVSO) is line managed by the Director of the Committee for Social Responsibility. The decision was taken in order to promote a culture of care and safeguarding in its widest sense. The DVSO also reports to the Diocesan Secretary and the Director of Human Resources (HR). Although the auditors wondered how well this split management would work, they found no indication that it does not work.

The DVSO reports that she can contact the Bishop at any time, although until recently seldom met face to face with him. This has been rectified and the Bishop and DVSO have a formal meeting to discuss and monitor the progress of cases every four to six weeks.

The DVSO works closely with the two Archdeacons and shares an office with them. The DVSO is not a member of the Bishop's Staff, which meets every three weeks, and the Archdeacons, the Diocesan Secretary and the Director of HR have traditionally reported to that meeting on her behalf. The Diocesan Secretary explained that safeguarding is on the agenda of this meeting but in terms of awareness and not case management.

The Bishop's Council is the board of directors of the charitable company, responsible for approving policy, and acts as a standing committee of the Diocesan Synod. It is also where decisions would be made if extra resources were required.

The structure of safeguarding in the Diocese is one where the DVSO appears to act as an adviser to the Bishop and the reports of her work to the Bishop's Staff are made by others on her behalf.

## 2.1.2 Safeguarding decision-making

In making decisions relating to safeguarding, the Bishop explained that he is advised by the DVSO<sup>1</sup>. He additionally may choose to take advice from others as appropriate to the case, namely the Registrar and/or senior clergy.

Making safeguarding decisions in any diocese can be challenging at times in particular in relation to thresholds for making referrals to statutory agencies of church officers. It is inevitable that there will at times be disagreement around differences of opinion and the issue for Chester is how these are to be swiftly resolved, especially if this disagreement is between the safeguarding professional and other people advising the Bishop, or ultimately with the Bishop himself.

This issue was highlighted in three of the cases audited and is discussed further in 2.10, along with considerations for the Diocese. The national systemic implications are addressed in 2.19 in relation to policy and to potential conflicts of interests in decision-making. The latter refers to compromising potential decisions around disciplinary matters (as indicated in Practice Guidance: Responding to Serious Safeguarding Situations Relating to Church Officers (June 2015 (7.20) and avoiding any potential conflicts arising from a decision-maker on safeguarding also having a pastoral responsibility for an alleged perpetrator.

### **Considerations for the Diocese**

*Consider the need to delegate operational safeguarding decisions, so as to avoid potential conflicts of interest and/or delay.*

*How safeguarding management in the Diocese could benefit further from the professional experience of the DVSO, so that her role is not just an adviser e.g. the DVSO could report on safeguarding directly at Bishop's Staff meetings.*

## 2.2 DIOCESAN SAFEGUARDING ADVISER/S

The Diocese has the benefit of a Diocesan Safeguarding Adviser (known as the Diocesan Vulnerability and Safeguarding Officer or DVSO in the Diocese) with good professional background in safeguarding and in management. This provides her with the experience and confidence to be able to assert her own views and challenge individuals at all levels about safeguarding as and when she considers necessary.

The DVSO post has been full-time since July 2014 when the current post-holder arrived. Prior to that, the post was shared with the dioceses of Liverpool and Manchester. Before July 2014, the diocese received 11 hours a week of DVSO time and four hours of training from a part-time trainer.

---

<sup>1</sup> Diocesan Vulnerability and Safeguarding Officer is the term for Diocesan Safeguarding Adviser in Chester

The DVSO is employed by the Diocese and paid. The DVSO is a suitably qualified and experienced professional, and receives professional supervision. Before joining the Diocese of Chester, the DVSO worked for 12 years in the equivalent role in the Roman Catholic Diocese of Shrewsbury. The DVSO's previous career was mainly in residential care and in the voluntary sector, and included management posts.

The DVSO has a Degree in Social Work. In 2008 she joined the CEOP (Child Exploitation and Online Protection) Academy and achieved a postgraduate Certificate in Behavioural Forensic Psychology in 2011. She is on the CEOP database as an accredited professional to assist the police in any investigations/ forensic interviews with sexual offenders, having undergone the same level of training as the police for their work within public protection and paedophile units. The DVSO is trained in the use of SVR (Sexual Violence Risk) – 20 assessments<sup>2</sup>. The DVSO is also qualified to undertake Type B Risk Assessments<sup>3</sup> and is a member of the Vatican's national independent investigation panel.

The DVSO has carried out independent social work consultancy for eight years, conducting formal risk assessments of sexual offenders and undertaking independent complex case reviews. She has been the safeguarding adviser for three international religious orders and is a member of the National Catholic Safeguarding Commission's independent investigation panel.

The DVSO has a job description and a person specification and it is consistent with national guidance and model examples.

The DVSO receives professional supervision from a Local Authority Designated Officer within the Diocese.

Since recruiting a full-time DVSO in 2014, the Diocese has benefitted from a suitably qualified and experienced safeguarding professional, who has the skills and ability that are needed in the role. However, the case audit demonstrated on three cases that her advice is not consistently followed, and decisions made which are not consistent with her professional advice. This is addressed in sections 2.10 and 2.19.

There are no considerations for the Diocese in this section.

---

<sup>2</sup> The SVR-20 provides a structure for reviewing information important in characterising an individual's risk of committing sexual violence and for targeting plans to manage that risk.

<sup>3</sup> A Type B Risk Assessment is commissioned by the Diocese or responsible body and referred to an independent agency or professional person qualified and experienced in safeguarding risk assessments. A Type B assessment will only be undertaken in relation to a church officer, whether ordained or lay, and on completion of a statutory investigation.

## 2.3 DIOCESAN SAFEGUARDING COMMISSION

A 'Safeguarding Commission' has replaced a former Safeguarding Advisory Group that was judged to be under-performing and performs the functions of what is called a Diocesan Safeguarding Management Group in many other dioceses. The Commission has met twice to date and would have met a third time, but for the audit dates. The DVSO modelled the Commission on the equivalent body in the Roman Catholic diocese in which she worked previously. The Commission meets quarterly and had Terms of Reference agreed at the first meeting in October 2015. The Diocesan Secretary then presented the Terms of Reference to the Bishop's Council in December 2015.

The Chair is independent and unpaid. He was a Circuit Judge with considerable experience of clerical abuse cases. Despite the best efforts of the auditors, it was not possible to meet or speak to the Chair during or after the audit. This led to a significant limitation of the ability of the auditors to be able to make much comment on the role of the Commission and his views about safeguarding in the Diocese.

The other members of the Commission are:

- the two Archdeacons
- the Diocesan Secretary
- the Director of HR
- the Director of the Diocesan Committee for Social Responsibility.
- a Local Authority Designated Officer
- a senior manager in The Probation Service
- a detective sergeant from the Public Protection Unit.

The DVSO attends all meetings and prepares the agenda. Minutes of the meetings are full and clear, but would benefit from having the roles of attendees added.

The auditors discussed with the DVSO and the Diocesan Secretary the potential benefit of an annual work plan that sets out agreed tasks and objectives for the year. Such a plan would support a wider ownership of actions agreed, rather than responsibility lying solely with the DVSO and enable the Commission to review progress regularly and consider how to overcome obstacles.

*(References: part 1 of S11 audit. Appoint a suitably qualified DSA, and provide financial, organisational and management support. The adviser must have full access to clergy files and other confidential material. Part 6: The DSA's role is clear in the job description and person specification. And: The DSA has sufficient time, funding, supervision and support to fulfil their safeguarding responsibilities, including local policy development, casework, advice, liaison with statutory authorities, training, personal and professional development and professional registration. Part 8: The DSA should be given access to professional supervision to ensure their practice is reviewed and improves over time.)*

### **Considerations for the Diocese**

*Consider drawing up an annual work plan that addresses the safeguarding priorities for the Diocese and undertake regular reviews of progress and impact.*

## 2.4 POLICIES, PRACTICE GUIDANCE AND PROCEDURES

The DSA reported that the quality of the safeguarding policy she found on her arrival was poor so she updated it as a matter of urgency. The policy is clearly written and easily accessible via the diocesan website. It covers policy and procedure at both diocesan and parish level. The auditors appreciate that this policy was written before the recent national policies and practice guidance but did not notice any discrepancies. However, the scope of the audit does not include provision to provide detailed comparison of the documents.

The policy refers generally to national policy and practice guidance but leaves the reader to access the Church of England website in order to find them. Links from the diocesan website would be useful and would give the message that the diocese is signed up to national safeguarding initiatives.

The auditors were given sight of a new web page that is ready to be uploaded. The new pages will include useful information such as phone numbers for national organisations plus the links to national policy and guidance. They might also include local phone numbers for referral to social services and/or the police, although they are given in handouts to parish safeguarding coordinators during their training events as they are the designated people who will contact the agencies, and they receive training on how to make a referral.

The auditors were told that the intention is to adopt national policies and practice guidance once they are approved by General Synod. This is an appropriate plan given the recent consultation version of new policy. It is understood that the Bishop's Council would need to agree to refer the decision to adopt to the Diocesan Synod for approval.

Section 6 of the policy refers to it having been endorsed by the Diocesan Synod. In the auditors' view, the policy would benefit from public endorsement by the Bishop in the form of a signed foreword. This would support the endorsement given last year when all clergy and lay readers were told that safeguarding training was a requirement.

There are points where the policy needs to be updated to reflect changes brought about by the Care Act 2014 (referred to as future legislation), Working Together 2015 and the introduction of the offence of controlling or coercive behaviour in the Serious Crime Act 2015.

The audit identified additionally that the complaints process needs improvement (see 2.12) and that the House of Bishops' Responding to Serious Safeguarding Situations in Relation to Church Officers (June 2015) does not appear to have been implemented in the Diocese (see 3.10 below) in relation to the lack of evidence of the use of core groups. A consideration has been made below on implementing this guidance urgently.

*(Reference: part 1 of the S. 11 audit: Ensure the Diocesan Synod adopts the House of Bishops' safeguarding policies, together with any additional diocesan procedures and good practice guidelines.)*

## **Considerations for the Diocese**

*Implement urgently the use of core groups to be compliant to the House of Bishops' Practice Guidance: Responding to Serious Safeguarding Situations in Relation to Church Officers (June 2015).*

## **2.5 RESOURCES OF SAFEGUARDING SERVICE**

The DVSO is supported by a part-time (20 hours a week) personal assistant.

The DVSO works from the diocesan office and shares a room with the two Archdeacons and their personal assistant. The Archdeacons reported that this arrangement means that they are always up to date with the progress of safeguarding cases, and the DVSO described it as being very helpful and supportive.

Working conditions are good; the office is bright, modern and spacious.

The total resource for safeguarding includes a retainer paid to CCPAS (The Churches Child Protection Advisory Service) who provide cover when the DVSO is on leave or off sick. The budget for safeguarding has almost quadrupled over the last two years, admittedly from a low base.

At present, the resource available is sufficient. The Diocesan Secretary and the Director of Human Resources were clear that, should further resources be needed, difficult decisions on reprioritising resources from other areas would be the only means to fund them. This was, though, said in a manner which indicated that such decisions would have to be made and not that it was an impossibility.

There are no considerations for the Diocese in this section.

## **2.6 RECORDING SYSTEMS AND IT SOLUTIONS**

The DBS process has been commissioned out to CCPAS and this would seem to be bedded in and to work well. It is entirely web-based and anyone unable to use a computer is invited into the diocesan office to complete the form online. The Diocesan Secretary and the Director of Human Resources are both 'super users' and can access complete reports on the status of DBS checks in the Diocese. Disclosures that contain information about previous convictions are passed to the Director of HR (picked up via the CCPAS system and by correspondence from CCPAS) whereupon the DVSO undertakes a full risk assessment, usually after an interview with the applicant. The DVSO provides a written response to the applicant. The Director of HR provides a written response to the Parish Safeguarding Officer and returns the DBS certificate to the applicant.

The DVSO's Personal Assistant keeps a record of who has received safeguarding training. Refresher training is an issue that needs some planning – see 3.8 below.

The DVSO, in conjunction with the Diocesan Secretary, made a decision to institute a paper-based system for record keeping when she arrived (before that it seems that recording was patchy). The content of the files is well laid out and the story of a case

was easy to establish, as was the reason for and date of referral. Storage is secure.

There are no considerations for the Diocese in this section.

*(Reference: part 1 of the S.11 audit: Provide access to the DBS checks for parishes, the Cathedral, the Bishop's Office and the Diocesan Office for those beneficed and licensed clergy, paid workers and volunteers who need to obtain disclosures.)*

## **2.7 RISK ASSESSMENTS & SAFEGUARDING AGREEMENTS**

The process for risk management has been put in place by the DVSO. A Covenant of Care<sup>4</sup> risk assessment meeting is held with police and/or probation. The process described by the DVSO is that the subject's proposed involvement with the Church, and all the risks, needs and rights are identified and assessed. The subject is included in the risk assessment, but not the parish. The record of the risk assessment is held by the statutory agencies, such as the probation service. The DVSO's view is that the diocesan responsibility is then to provide the safe boundaries set out in the terms of the Covenant, and not to provide the risk-management process in a documented audit trail. The priority is for the Covenant of Care to be clear in its finalised form so that its parameters are known and understood. This does, however, mean that the parish is not party to the risk evaluation and must accept the parameters of the Covenant.

The DVSO explained that her reluctance to share the written assessment document with parishes was based on her understanding that this was contrary to data protection requirements and she had discussed this with the NST. The Practice Guidance (Risk Assessment for Individuals who may Pose Risk to Children or Adults, 2015), at 5.26 does refer to the need to share the assessment albeit with the proviso of obtaining permission to share third-party information and possible redactions. The auditors hold that it is important that this is followed in order that those implementing the Covenant, have full understanding of the risks and how the plan serves to manage these.

The auditors read seven case files that included live Covenants of Care. It was seen that, two years ago, Covenants of Care were at an early stage of development. There was a reference to an 'informal' (unwritten) Covenant in one case, the incumbent was initially difficult to engage in two cases, and the DVSO found the subject of the Covenant to be in a relationship with a member of the support group in another.

There was evidence that practice had since developed. All parties had signed the agreements and careful consideration is given to the parameters of contact with the Church in liaison with local parishes and statutory services. The auditors saw good practice in Covenants being applied to those convicted of an offence, those awaiting trial and those about whom there has been an allegation but no prosecution is planned.

---

<sup>4</sup> A Covenant of Care is the name for all agreements that set out the terms relating to alleged or actual offenders and church attendance in this diocese.

There was evidence of review of the Covenants. The DVSO explained the process in place by which a review date is agreed when the Covenant is introduced. The date could be between four weeks and three months, depending on the complexity of the issues involved and the pathology of the offender/alleged offender, and a planned review is made thereafter. Reviews are tracked by the DVSO's Personal Assistant.

Following a Covenant review the new document is drawn up and sent out and requires signatures from a number of people. It is then returned to the DVSO and is photocopied and distributed to relevant parties, and the original copy is placed on the DVSO's file. This can take several weeks or more and often requires chasing up.

The DVSO takes part in the agreement and review of all Covenants at present but acknowledged that, in the future, some might safely be left to the parish.

The Diocese has not yet commissioned a Type B Risk Assessment and the DVSO was clear that she should not undertake any herself within the Diocese due to the potential conflict of interest.

*(Reference: part 1 of S. 11 audit: Provide access to a risk assessment service so the Bishop and others can evaluate and manage any risk posed by individuals or activities within the Church.)*

### **Considerations for the Diocese**

*Consider how best to involve the parish in the risk assessment process, so that they have a full understanding of the identified risks and how these are to be managed.*

## **2.8 TRAINING**

All training is delivered by the DVSO and 25 sessions were delivered in 2015. Members of the Focus Group said that, prior to mid-2014, training was patchy and of variable quality. A part-time trainer had been employed.

The DVSO is working through a considerable backlog of people who need training. The clergy were prioritised (several people referred to the Bishop using a 'three-line whip') and almost all have now received training. The Bishop individually exempted a few retired clergy with Permission to Officiate (PTO) on the grounds that they were too infirm to attend. This seems to be a result of an informal policy not to refuse the renewal of PTO on the grounds of infirmity.

It has not been possible yet to establish a three-year cycle of refresher training and this will present a new challenge. The use of an e-learning package had previously received negative feedback but may need to be re-considered and/or the support of suitably skilled volunteer trainers. The DVSO has been delivering 25 training sessions a year and reported that this is too many to become 'business as usual'. However, the DVSO and members of the Focus Group were quick to point out the added value of delivering face-to-face training, in that the DVSO becomes known and, quite often, referrals follow. Also, the participant feedback on the training was very positive and Focus Group members talked warmly about the benefits of the small group exercises in which they shared views on a scenario.

The auditors and the DVSO discussed the possibility of formalising a draft training plan, which would scope the size of the task in terms of numbers and levels of training needed and set out how training needs will be met. It is acknowledged that much of this is known to the DVSO but the advantage would be that a plan would enable wider ownership of the problem and solutions.

The practical arrangements for training such as advertising, booking places, meeting and greeting, keeping records of people trained, etc. are the responsibility of the DVSO's Personal Assistant and this system was seen to starting to work well.

*(Reference: part 1 of S.11 audit: Select and train those who are to hold the Bishop's Licence in safeguarding matters. Provide training on safeguarding matters to parishes, the Cathedral, other clergy, diocesan organisations, including religious communities and those who hold the Bishop's Licence.*

*And to part 8: Those working closely with children, young people and adults experiencing, or at risk of, abuse or neglect ...have safeguarding in their induction and are trained and have their training refreshed every three years.)*

### **Considerations for the Diocese**

*The use of a formal training plan, agreed by the Bishop's staff, to meet the backlog of those that require training, including those requiring a three-year cycle of refresher training.*

## **2.9 SAFE RECRUITMENT OF CHURCH OFFICERS**

A total of six Blue Files were audited for evidence of Safer Recruitment. This is a very small sample and the evidence it presented was inconsistent. An overall comment would be that too much material is loose on the Blue Files and that they would benefit from more consistent organisation that lessens chances that anything gets lost.

The date of the last DBS was at the front of five of the files, and findable on the sixth. Four files had references for the most recent post.

The most thorough recruitment process was seen for a priest who was previously unknown to the Diocese and who wrote to ask for permission to apply for a specific post. The file contained a Clergy Current Status Letter from his previous bishop, an application form, a CV and four references.

The other five files were of clergy moving within the Diocese:

- One contained a letter from the Bishop to the Parochial Church Council proposing the person as their next incumbent: this file showed no evidence of an application form or references.
- Another file contained emails from the Bishop to the clergy person advising him where he might apply, an application form but no references.
- The three other files contained both application forms and references.

A further six Blue Files were read to check the tie-up between this file and safeguarding files, as these six individuals were the subject of concerns or allegations investigated by the DVSO.

On one, a case that has not yet reached a conclusion, there was clear evidence of the allegations and the Notice of Suspension in a letter from the Bishop of Chester to the Bishop of the Diocese in which the subject currently lives. The auditors were concerned that the material relating to the (serious) safeguarding allegations was in plastic pockets which were loose in the Blue File and which does not provide a secure method of storage.

Four further files were recent (relating to cases active since July 2014). All four showed evidence of the relevant safeguarding concerns.

A further file, dated from over 20 years ago, showed a brief mention of the allegation, admitted by the subject. This case was picked up in the Past Cases Review in 2009 and was copied to the police in 2014, at their request. It has now been requested by The Independent Inquiry into Child Sexual Abuse (IICSA, formerly known as the Goddard Enquiry), hence the request to the auditors to read it. The Bishop agreed that there was much that was concerning about this case and the auditors acknowledge that he has tried to obtain the subject's address, so that statutory agencies can follow him up, but without success.

The auditors did not see human resources files relating to lay appointments in the Diocese, and would have struggled to examine any within the time available.

*(Reference to part 7 of S.11 audit: The Diocesan Secretary has implemented arrangements in line with the House of Bishops' policy on Safer Recruitment 2015.*

*And to part 1: Keep a record of clergy and church officers that will enable a prompt response to bona fide enquiries...where there have been safeguarding concerns, these should be clearly indicated on file.)*

### **Considerations for the Diocese**

*Consider developing and agreeing a consistent approach to organising relevant evidence and secure method for attaching it on the Blue File, when any member of the clergy has been the subject of a safeguarding concern or allegation.*

## **2.10 RESPONSE TO ALLEGATIONS**

A total of 17 case files were audited. All the files show a quick response by the DVSO, an excellent pace to the subsequent enquiries and/or investigation and equally good use of liaison with statutory agencies. The DVSO provided contact details of colleagues in local authorities and the police to the auditors although direct contact is not a planned part of the audit. Some of the files showed evidence that, prior to the DVSO's arrival and the training programme, safeguarding was much less well understood in some parishes. One file showed that a similar allegation to a current one had gone unreported some five years ago by the previous vicar. In contrast, the current vicar had reported the allegation promptly. Another file showed that an incumbent thought he 'categorically knew' that a sex offender was no risk to children in 2014 and thought the Covenant of Care punitive. When the auditors followed this up with the DVSO, she was confident, having trained him, that the incumbent would not have the same views now.

The auditors had concerns in relation to three cases that involved allegations or concerns against church officers:

- In one case there were concerns about there being too little scepticism of an alleged perpetrator.
- Two cases involved issues around the decision-making in relation to making referrals to statutory agencies, with disagreements around whether or not the thresholds had been reached – one of these cases also highlighted the lack use of core groups in the Diocese (in accordance with section 7, Practice Guidance: Responding to Serious Safeguarding Situations Relating to Church Officers, June 2015).

The four issues raised through these cases are discussed in detail below:

- culture of too little scepticism
- responsibility for threshold decisions about referrals to statutory agencies
- lack of use of core groups
- written communications to alleged perpetrators and offenders.

National systemic implications are in 2.19.

### **2.10.1 Culture of too little scepticism**

In one case, it was observed that there had been too much trust placed in what a member of the clergy said. This raised concerns for the auditors about an adequate acceptance of the ever-present possibility of senior clergy being groomed by actual or potential abusers, which can lead to alleged perpetrators being wrongly believed at the expense of alleged victim/s.

In one case, the police decided on no further action (presumably as insufficient evidence for a criminal prosecution), but advised that, on balance of probabilities, the alleged perpetrator should not continue in his role. This highlights the different standards of proof used for the legal process as opposed to safeguarding decisions. The subject of the allegations 'agreed' to have no unsupervised contact with children during a disciplinary process. The auditors considered that this might give the alleged perpetrator too much control. Although the Bishop does not have the legal authority to insist that the subject have no unsupervised contact with children, he might nonetheless have demanded it to make it clear that the priority is safeguarding and the risk of harm to children and vulnerable adults, as opposed to legal proof.

The Bishop observed that this diocese has fewer historic cases involving safeguarding than some other dioceses. This raised a question for the auditors, about whether the lack of such experience has resulted in practice still being based on admission or a definitive judgement of guilt, as opposed to current good practice which is based instead on risk.

### **2.10.2 Responsibility for threshold decisions about referrals to statutory agencies**

As explained in 2.1, the Bishop of Chester does not delegate any of his safeguarding responsibilities and takes all decisions about if and when the threshold for referral to statutory agencies takes place.

Whilst this provides consistency and strong leadership in safeguarding, the cases audited revealed the risks also entailed due to the possibility of considerable delay and disagreements that it allows, in decision-making about whether or not to make a referral statutory services. In one instance, a case was referred but only after considerable delay. The auditors understood that delay was in part around the understanding of the level of evidence needed to make a referral (see 2.19 for discussion about thresholds for referral). After receiving the advice of the DVSO to make the referral, further advice was sought by the Bishop first from the Independent Chair of the Safeguarding Commission (who advised of the need to refer and also the risk of liability if this was not done), and secondly for further legal opinion from the Registrar.

Good safeguarding practice requires timely referrals and tackling delays requires understanding the reasons for them. Therefore, the audit sought to understand where disagreements stemmed from between the DVSO and the Bishop, evident in the Bishop's need to seek further advice. What seems to lie behind the disagreements is a different view taken on the threshold for referrals by the DVSO, the Bishop and other legal advisers whose views are sought.

Part of the problem stems from the way that the Practice Guidance: Responding to Serious Safeguarding Situations (2015) addresses the questions of threshold, as explained in 2.19 below. The DVSO takes the broader threshold indicated in 3.6 and 3.8 of the guidance, which requires that 'all concerns about the welfare' of children or adults be referred, and so advocated that this happen immediately.

The contrasting view, is that a referral should not be made until there is some confidence that there is sufficient evidence of abuse occurring. This is congruent with 3.5 of the guidance which refers to the threshold not being met because no offence has been committed or the alleged harm does not warrant referral. In these circumstances the guidance advises that the Diocese should investigate the matter internally. This is what happened to some extent in these cases and is what the auditors understand was the thinking behind the decision-making. Consequently for one case, there was considerable delay in the making of the referral and in the second no referral was made, against the advice of the DVSO, due to a different opinion about whether the alleged victims were or were not vulnerable adults.

The undertaking of further internal investigations can also be problematic, if the threshold has in fact already been met, as the way concerns and allegations are then followed up should be in accordance with a plan formulated in strategy discussions with police and the local authority.

In neither case did the DVSO seek consultation with the local authority or the police. The guidance does suggest this in the case of children, but does not cover adults (see 2.19). Such consultation would be extremely helpful in deciding whether thresholds are met, but does involve sharing of information, which would in Chester require agreement from the Bishop.

Having the professional responsibility for safeguarding without the authority to make decisions about the need or not for a consultation or a referral can pose dilemmas for the individual concerned. In Chester, such ethical conflicts led to the DVSO referring herself to her own professional body when concerned about the possibility

of a threat to her own integrity and professional registration. The question of where such responsibility should lie is a national issue and addressed in 2.19.

The priority for Chester is to be able to agree a way of working which minimises risk to children and vulnerable adults, makes best use of the professional expertise available, and includes a way to resolve differences of opinion, especially around decisions relating to the referral or not of children or adults about whom there are safeguarding concerns.

### **2.10.3 Lack of use of core groups**

A contributory factor to the lack of earlier referral may also have been the lack of use of core groups in these cases, in accordance with section 7, Practice Guidance: Responding to Serious Safeguarding Situations Relating to Church Officers (June 2015). The function of a core group is to provide the internal management of every serious safeguarding situation, so all recommendations are taken by this group and could decide on an earlier referral. In principle, the work of the core group replaces the process of a Bishop seeking further advice. In consequence, a core group might have decided to make such a referral earlier than the Bishop did in one of the cases discussed above.

However, compliance with the Practice Guidance about core groups would seem to require that Bishops delegate decision-making about safeguarding referrals to the core group. Whilst the guidance precludes the Bishop from being a member of the group, 'in order not to compromise potential decisions about disciplinary matters which rest with him or her'(7.20), it also refers to 'recommendations' as opposed to 'decisions', which means that the Bishop remains the ultimate decision-maker. This is a potential systemic weakness, and is discussed further in 2.19 below.

The need to implement use of core groups is addressed in 2.4 above.

### **2.10.4 Written communications to alleged perpetrators and offenders**

The auditors had concerns about some of the phrasing used when writing to alleged perpetrators and offenders, or to people who are writing in support of them. This could be seen as colluding with the minimisation of actual or alleged offences and/or could be hurtful to survivors in the future should it become public. The auditors have in mind words used to describe the complainants in two different cases, which could be (mis) interpreted to minimise the offences. To minimise unintended insensitivity the auditors suggest, every time anyone writes to an alleged or actual perpetrator, that they hold in mind how a victim might perceive what they are saying.

#### **Considerations for the Diocese**

*The Diocese to consider how decision-making about safeguarding, with particular reference to the making of referrals to statutory agencies, can maximise the safety of children and vulnerable adults and make best use of professional safeguarding experience and judgement: such consideration to include use of consultation facilities with agencies for adults, as well as children and obtaining advice from the National Safeguarding Team (NST).*

*Consider the need for senior clergy and diocesan senior managers to be provided together with training on the grooming process in the Church.*

## 2.11 QUALITY OF CASEWORK

The quality of casework is sound throughout the 17 cases audited. Allegations or concerns are clear, there is a log of actions taken and outcomes are noted. Occasionally, the auditors found it difficult to establish a person's professional role during a string of emails.

The DVSO is very proactive in referring to and consulting her professional colleagues. There was a lot of evidence on the records of contact with the police, designated officers, probation officers, etc.

The DVSO employs an inclusive definition of safeguarding. For example, she was contacted by one parish about an elderly man in the early stages of dementia. He had been banned by the parish centre as he behaved inappropriately and could be disruptive. The DVSO engaged the Alzheimer's Society to provide training for the parish and the outcome was a dementia-friendly parish and an old man who could continue to attend the centre.

There are no considerations for the Diocese in this section.

## 2.12 COMPLAINTS

The auditors were provided with a diocesan complaints procedure which is very brief and refers only to complaints about the service received from staff at Church House. It does not come up via the search engine on the diocesan website.

The auditors were told that the procedure is in the staff handbook as an appendix, and dated July 2011. The staff handbook can be accessed via a search on the website and is dated April 2016.

There is also a comments and complaints procedure for parishes in the diocesan safeguarding policy. This is a form for use when complaining to the PCC.

The auditors discussed the potential advantages of adopting a three-stage process to dealing with complaints, namely an informal stage (at which the aim is to resolve the majority of complaints), a formal and independent investigation stage and a final appeal stage.

*(Reference: part 1 of S. 11 audit: Provide a complaints procedure which can be used by those who wish to complain about the handling of safeguarding issues. Also part 4: There is an easily accessible complaints procedure including reference to the Clergy Disciplinary Measures and whistle blowing procedures.)*

### **Considerations for the Diocese**

*Consider whether to write and implement a formal complaints procedure that allows for complaints by service users on the safeguarding service and offers a three-stage process.*

## 2.13 WHISTLEBLOWING

The whistleblowing policy and procedure are comprehensive. They are also published as an appendix to the staff handbook and appear at the end of an alphabetical list of policies and procedures. A search on the website takes you to the staff handbook and makes it clear that it contains the whistleblowing policy.

The distinction between a complaint and whistleblowing is made and it is clear to whom whistleblowing should be addressed (the Diocesan Secretary or the Director of Human Resources). Contact numbers or email addresses are not given but would be available to staff.

The policy also allows for a lack of trust in the employing organisation and includes information about a relevant non-profit making organisation, Public Concern At Work. A check on the website for this organisation showed that it would seem to have moved and the address and phone number given in the staff handbook are now invalid.

*(Reference: part 4 of S. 11 audit: Whistleblowing arrangements are in place and addressed in training.)*

### **Considerations for the Diocese**

*Replace the contact details for Public Concern At Work in the whistleblowing policy.*

## 2.14 MONITORING OF SAFEGUARDING IN PARISHES AS PART OF ARCHDEACONS' RESPONSIBILITIES

A previous regime of quinquennial parish inspections by the rural deans has been replaced, since 2011, by triennial inspections by the archdeacons. Safeguarding is one of the areas monitored.

The archdeacons explained that they do not send annual Articles of Enquiry as they find it becomes a paper exercise, and not valued by the parish. They prefer to use Survey Monkey for more specific questions and find they get a good response. The auditors understand that the use of Articles of Enquiry is a matter for the Diocese to decide and not a national requirement.

The archdeacons are pleased with the seriousness with which safeguarding is viewed by the majority of parishes. They have not found any parishes that are at an unsafe stage in their awareness of or response to safeguarding. If they did, they were confident that they would explain the necessity of engaging with safeguarding, backed up by the possibility of disciplinary measures.

The diocesan self-audit for 2015 reported that 213 of 270 parishes had a Parish Safeguarding Coordinator (PSC). The archdeacons said this figure has improved since then, although were unable to state the exact number as parishes do not always report the appointment or resignation of a PSC, despite regular reminders in newsletters.

Records of parishes and safeguarding requirements are at an early stage. There are plans to collate a basic level of information about parish safeguarding policies, parish safeguarding representatives, the people trained, etc. at diocesan level.

*(Reference: part 1 of the S. 11 audit: Include the monitoring of safeguarding in parishes as part of the archdeacons' responsibilities.)*

### **Considerations for the Diocese**

*Consider how the archdeacons might use information from the annual self-audit at parish level, in conjunction with information kept by the DSA, to analyse the state of safeguarding in the parishes and to direct their efforts.*

## **2.15 RESOURCES FOR CHILDREN AND VULNERABLE ADULTS**

Authorised listeners are provided and trained by CCPAS. A confidential phone number is provided in the safeguarding policy and a website search takes you to a reference to the relevant page of the policy. The auditors were told that, as far as the DVSO was aware, the service had not yet been used but neither was CCPAS being asked to provide information about take-up. Since the audit, the auditors were informed that the service was used in June. The DVSO explained that all parish safeguarding representatives were informed when the service was set up and it is included in all safeguarding training.

The diocesan Committee for Social Responsibility includes a team of 10 unpaid counsellors, available to survivors as well as other clergy and lay people. The auditors were told that all are qualified and have professional supervision. The counselling service is offered to all complainants and others affected by their abuse. The strict confidentiality applied to counselling means that the DVSO is not informed whether counselling has been taken up. The DVSO had been involved in arranging local counselling for a victim who is no longer living in the Diocese.

*(Reference: part 3 of S.11 audit: There is a structure to hear the views of young people, there are children's and young people's advocates available, there are Authorised Listeners in place.)*

There are no considerations for the Diocese in this section.

## **2.16 INFORMATION SHARING**

The DVSO and the archdeacons agreed that, if a referral was not made directly to the DVSO, the archdeacons referred on as soon as they had the information. There was evidence that, when a case involved a member of the clergy, there may be delay in the communication between the Bishop and the DVSO, or a delay in action being taken due either to disagreement about what that action might be or to the Bishop denying permission to take action. This is closely linked to the issues of responsibility for decision-making about referrals (see 2.10).

The DVSO was clear that, in terms of children, she works to the requirements of Working Together 2015 which refers to the non-statutory advice on Information Sharing published by HM Government in March 2015. There are not currently formal information-sharing protocols with statutory agencies and it might prove useful to develop them with adult and children's safeguarding boards.

The auditors saw evidence of the DVSO working effectively and sharing information with statutory agencies and other dioceses. In one case, the other diocese did not

take up the offer of help to assess risk for a Covenant of Care. On the same case, the DVSO was not given permission by the Bishop to share information with the other diocese.

*(Reference to part 1 of the S. 11 audit: Ensure that the DSA is informed of any serious safeguarding situation, including any allegation made against a member of the clergy or anyone else holding the Bishop's Licence, concerning misconduct.' Also: Share relevant information about individuals with other dioceses, other denominations and organisations or the national church as appropriate. And to part 5: The Diocesan Secretary, who will have a lead on Data Protection Act matters, will ensure that there is clear information-sharing protocols in place.)*

#### **Considerations for the Diocese**

*The Diocese to consider how decision-making about safeguarding, with particular reference to information sharing with statutory agencies and other dioceses, can maximise the safety of children and vulnerable adults and make best use of professional safeguarding experience and judgement: such consideration to include use of consultation facilities with agencies for adults, as well as children and obtaining advice from the National Safeguarding Team (NST).*

*Consider approaching the relevant safeguarding boards to develop an information-sharing protocol between the Diocese and statutory agencies.*

## **2.17 QUALITY ASSURANCE PROCESSES**

Quality assurance is at a relatively early stage, given the short life to date of the Safeguarding Commission. The Terms of Reference state that the Commission will '...satisfy itself that there are robust and safe processes and systems in place...for safeguarding children and adults from abuse'. How this is to be done needs further working out.

There is a tool for an annual parish-level self-audit of safeguarding in the diocesan policy. This covers the number and response to allegations about the safeguarding of children and adults and to allegations about domestic abuse, and any agreements (Covenants of Care) with offenders or those who pose a risk. It also provides a format for an annual action plan. At present, these self-audits are not shared with the Diocese. They will be mandatory from late 2016. Parish safeguarding coordinators and clergy have received training on how to carry out the audit and refresher training will be provided in January 2017.

#### **Considerations for the Diocese**

*Consider how the Safeguarding Commission will satisfy itself that processes and systems are robust and safe, and how (and to whom) this will be reported.*

## 2.18 LINKS WITH NATIONAL SAFEGUARDING STRATEGY AND TEAM

The DVSO has close working links with the national team and represents the northern dioceses on the Joint Safeguarding Working Group, the national team's working group. Hence she has a good idea of the direction of travel and piloted the national training package.

There are no considerations for the Diocese in this section.

## 2.19 NATIONAL SYSTEMIC SAFEGUARDING ISSUES

### 2.19.1 Threshold for referrals to statutory agencies

This audit has drawn attention to varied interpretations of the threshold for referral suggested in the current Practice Guidance: Responding to Serious Safeguarding Situations (2015). SCIE understands that this guidance is currently being revised. The following reflections may therefore be useful to any such revision.

Firstly, there seems to be contradictory representations of what the threshold is for referral to statutory agencies. The first procedural advice in the guidance about the threshold for making a referral addresses what to do if the threshold has not been met. It includes two examples:

*'If the threshold for reporting to statutory agencies has not been reached, for example, if no criminal offence has been committed, or the alleged harm done to an adult victim or survivor does not warrant a referral to Adult Services, the Diocese should investigate the matter internally.'* (3.5 Responding to Serious Safeguarding Situations Relating to Church Officers, 2015)

The second example – 'if alleged harm does not warrant a referral' – does not in itself help clarify what would count as warranting or not warranting this. The first example – 'if not criminal offence has been committed' – is a problematically narrow and categorical definition not least because it excludes any risk of harm that has not yet been committed. It is contradicted a few paragraphs later, where a much broader explanation of the threshold is provided:

*'All concerns about the welfare of children must be referred to either the police or Local Authority Children's Services without delay'*(3.6) and

*'All concerns about the welfare of an adult should be referred to Local Authority Adults Services by either the adult who is an alleged victim or the DSA. The police should also be informed if it is believed a crime has been committed.'* (3.8)

Secondly, there is a difference in the advice given between cases of children and those involving adults, about what to do when there is a lack of clarity if the threshold is reached. In the case of children, the guidance suggests seeking consultation with the local authority. It does not do so in the case of adults. It is of note that in Chester,

the cases where there was disagreement concerned the welfare of adults and where no such consultation provision is in the guidance.

Thirdly, and in the absence of prior consultation with the local authority, the guidance instructs further internal investigation prior to referral for those deemed not to meet the threshold. The risk of this is that such internal investigation can risk police investigations (if they are warranted) and, where there are internal disagreements, about the threshold level for referral, a safer approach would be to seek consultation first in such circumstances.

Lastly, and linked to this, the guidance provides no recognition of, or guidance on dealing with potential confusion internally or disagreement about the threshold level for referral.

We discuss the issue of where responsibility for safeguarding decision-making lies in a diocese below. Here we note only that where that decision-making lies with those other than the DSA, there is a risk of disagreement and it is especially vital that there is a clear and fast route for resolution, involving consultation with either the local authority, police or the NST.

### **2.19.2 Safeguarding decision-making**

The auditors in Chester were made aware of the tensions that exist around safeguarding decision-making processes in the Diocese. Such tensions could exist regardless of whether or not the Bishop delegated responsibility for some or all of the decision-making to others. Some of the issues in Chester are associated with the positive open debate that exists, as well as the experience and confidence of the DVSO in being able to challenge senior clergy.

However, the lack of delegation of such safeguarding decision-making can cause potential problems. For the safeguarding adviser role, there may be perceived difficulties around professional responsibilities as explained in 2.10. For the Bishop there could be issues around compromising potential decisions around disciplinary matters, as indicated in Practice Guidance: Responding to Serious Safeguarding Situations Relating to Church Officers (June 2015 (7.20).

Of note also is recommendation six of the report of the 'Inquiry into the Church of England's response to child abuse allegations made against Robert Waddington' (the 'Cahill Report'), that decision-makers should not have a pastoral responsibility for the alleged perpetrator. The context was the view of the inquiry that the previous Archbishop of York had allowed his sympathy for Waddington to lead him into disregarding risk and to making flawed decisions. Paragraph 16.20 reads:

*'...No person should be expected to balance the needs of others as against the needs of someone for whom s/he has pastoral responsibility. Paragraph 16.21 adds, '...We therefore recommend that anyone who has pastoral responsibility for a person within the Church should not have the authority to make child protection decisions in relation to that person if they are the subject of a child protection or child abuse allegation. That means that whilst Bishops and Archbishops may be consulted, it should be someone qualified and independent of the Church who makes the final decision whether a matter should or should not, be reported to the statutory agencies or police.'*

The auditors are aware that this recommendation is not policy within the Church. It does though raise one of the underlying systemic difficulties there can be in decision-making relating to allegations of church officers, and consequently the need for a national position on the appropriate safeguards to minimise any potential for conflicts of interest involved in any decision-making about referrals to statutory authorities.

The current practice guidance refers to the role of the DSA (Diocesan Safeguarding Adviser) being the individual who communicates with the statutory agencies, but does not make reference to where the decision-making should lie within the Diocese. It may be impossible to do this given the different interpretations Bishops are making of the law as pertains to their safeguarding responsibility meaning that such arrangements vary. Making available accessible information on the variety of arrangements and the relative strengths and risks that each need to manage, could therefore prove helpful.

*(Reference: part 1 of S.11 audit: Provide a structure to manage safeguarding in the Diocese'. Also to part 2: The Bishop appoints a member of his senior staff to be the lead person for safeguarding.)*

### **2.19.3 Core groups – thresholds and decision-making**

The Practice Guidance: Responding to Serious Safeguarding Situations Relating to Church Officers (June 2015 (7.20) provides the following instruction about the internal management of safeguarding cases, so that:

*'In every serious safeguarding situation which relates to a church officer, the case should be managed by a defined core group, convened for the specific situation.'*

This does not, however, provide a ready solution to issues raised by a Bishop opting not to delegate safeguarding responsibility, described above. This is in part because there is no advice about what constitutes a 'serious safeguarding situation other than:

*'Most serious situations will involve referral to the police and/or Children or Adult Services. In the event of this threshold not being reached, on the advice of the Local Authority Designated Officer the Diocese/NCI should conduct its own investigation; the core group should establish a process for this, and if necessary commission an independent investigator to gather information and make an assessment on the facts.'*

In consequence, if there is a delay in consulting or making a referral to statutory agencies there may be a delay in setting up a core group, especially if the view is that further investigation is needed prior to deciding if the case does indeed meet this threshold. It may be that cases considered serious by some, would never reach this threshold if the decision-maker decides no referral is required.

Further, as explained in 2.10, the Bishop must not be a member of the core group, 'in order not to compromise potential decisions about disciplinary matters which rest with him or her' (7.20). However, the Bishop retains the decision-making of all safeguarding decisions, unless they choose to delegate these to the core group, as indicated by the 7.19 of the practice guidance:

*'The role of the Chair is to ensure that policy and practice guidance is followed, and to communicate to the Bishop/Archbishop any recommendations made by the core group, always in the knowledge of the DSA/NSA.'*

#### **2.19.4 Relationships between clergy and parishioners**

The Bishop shared that he would appreciate clarity from the national team about the degree to which the relationship between priest and parishioner is comparable to that between a doctor and patient, in that the doctor is in a position of trust and it is not acceptable to have an intimate relationship with a patient. He also suggested it would be more straightforward if such a sexual relationship is *prima facie* a criminal offence, whilst acknowledging that it would require careful legal definition.

The Guidelines for the Professional Conduct of the Clergy (2015) contain references to the moral responsibility of the clergy and to the need to beware of the potential abuse of the power dynamic, especially if the Church's broad definition of a 'vulnerable adult' is used. It is clear that 'clergy must never have sexual or inappropriate relationships with those aged 16 or 17, or vulnerable adults. A breach of this requirement, in addition to being treated as a disciplinary matter, will be referred to the Local Authority Designated Officer. In some cases, it may constitute a criminal offence'.

There are further restrictions on personal relationships in other professions, and in particular in medicine, arising from the duty of care. Whether clergy should or should not be subject to such standards is one that needs to be considered nationally in a wider arena than a safeguarding audit.

## **3 CONCLUSIONS**

### **3.1 WHAT IS WORKING WELL**

The current Diocesan Vulnerability and Safeguarding Officer (the term for Diocesan Safeguarding Adviser in Chester) joined the Diocese 22 months ago, when safeguarding was at a low base. The Diocese has moved a long way in a short time. The DVSO has identified what further work is required and safeguarding is now clearly on the agenda of senior clergy as demonstrated by the Bishop's successful 'three-line whip on clergy training. The Focus Group members were clear that the bishops are promoting messages about safeguarding.

The DVSO is social work-qualified, experienced, knowledgeable, well connected with statutory services and pastorally sensitive. She is a skilled trainer and receives good feedback from training. The Bishop expressed to the auditors his complete confidence in the DVSO and Focus Group members all spoke highly about training, availability and support.

The case files are well ordered, it is easy to see what happened and the reason for referral. The log at the front provides a useful summary of actions taken etc. The auditors were satisfied that all the files would make sense to anyone reading them in years to come.

The auditors saw a high level of awareness about adult safeguarding and were offered a good number of adult cases to audit. The Focus Group talked readily about adult safeguarding and showed pride in the recent development of dementia-friendly churches.

The archdeacons reported no pockets of resistance among the parishes.

The auditors saw some effective awareness of and response to the voices of victims both by the Bishop and the DVSO.

The Diocese has a very complete whistleblowing policy for use by staff and it was easily found via the website. It includes information about a relevant non-profit making organisation, Public Concern At Work, should an employee lack trust in the Diocese.

It is too early to comment on the impact of the Safeguarding Commission, but the membership and Independent Chair are strong and it has made a good start.

### **3.2 WHAT NEEDS TO WORK BETTER?**

The Findings (section 2) provide the detail of the areas for improvement in safeguarding.

The need to make referrals to statutory agencies in a timely manner is a priority. The reasons behind some of the obstacles vary and are explored in 2.10 and 2.19. The Diocese urgently needs to agree a process which is able to meet professional safeguarding expectations and avoid the possibility of an internal investigation which

could in any way compromise any enquiries the police or the local authority may need to make.

Closely allied to this is the need to fully implement the use of core groups (see Practice Guidance: 'Responding to Serious Safeguarding Situations in Relation to Church Officers (June 2015), along with an understanding that once they have been initiated the decision making for referral will be undertaken by the core group.

## APPENDIX: REVIEW PROCESS

### DATA COLLECTION

#### Information provided to auditors

- Diocesan Safeguarding and Vulnerability Policy and Procedures: 'Safe In Our Care'
- Self-Assessment of Diocesan Safeguarding Arrangements 2015 (national audit)
- Report by the Independent Reviewer on the Review of Past Cases (November 2008)
- Whistleblowing policy
- Complaints procedure
- Minutes of the Diocesan Safeguarding Commission 29.10.2015 and 25.02.2016
- Terms of Reference of the Diocesan Safeguarding Commission
- Job description for the Vulnerability and Safeguarding Officer (DSA)
- Sample Training Evaluation Sheets for training for clergy, parish safeguarding coordinators and parish volunteers

#### Participation of members of the Diocese

The auditors had face to face conversations with:

- the Bishop
- the Archdeacons of Chester and the Archdeacon of Macclesfield
- the Diocesan Vulnerability and Safeguarding Officer (DSA)
- the Diocesan Secretary
- the Diocesan Director of Human Resources
- the Diocesan Director of Social Responsibility
- the PA to the Diocesan Vulnerability and Safeguarding Officer

The focus group comprised:

- two vicars of parishes
- two trainee lay readers
- a Parish Safeguarding Coordinator
- the Director of Studies (Bishop's Licence)

#### The audit: what records / files were examined?

The auditors examined:

- 17 case files, of which six were clergy and seven related to Covenants of Care
- the Blue Files of the six clergy who had been subject to an allegation or a safeguarding concern
- six further Blue Files were read for evidence of safer recruitment.

## LIMITATIONS OF THE AUDIT

The auditors were unable to meet or speak with the Independent Chair of the Safeguarding Commission, either during or after the site audit. As a result, they were unable to obtain his views about the safeguarding 'journey' in the Diocese, how the Commission will develop in terms of oversight of safeguarding or any impact he sees of the Bishop's practice of making all safeguarding decisions when the allegation concerns a member of the clergy. The Independent Chair would usually provide a knowledgeable but independent view.

The Focus Group had only one Parish Safeguarding Coordinator and lacked representation from other lay roles such as church wardens, youth leaders and administration officers. The purpose of the Focus Group is to gather information about how safeguarding knowledge and practice are developing on the ground and about the relationship between diocesan officers and parishes. The auditors were able to obtain a less complete view that they would have wanted (bearing in mind that any such group will represent only a tiny minority of parish workers).

Finally, none of the senior clergy in the Diocese attended the feedback session, although two lay members of the Bishop's Staff Team (the Diocesan Secretary and the Director of HR) attended. Neither was the Bishop represented, although he did make himself available for a substantial phone conversation with the report author shortly after the audit. They were unaware that this is an integral part of the audit and often enables some issues to be debated and resolved on the spot. This had an impact on the auditors' engagement with the senior clergy team.